SHIP Navigation Guide

Book 2

ship state health insurance assistance programs
NATIONAL NETWORK

LOCAL HELP FOR PEOPLE WITH MEDICARE

2/18/15

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Section G: Medicare Supplement Insurance

Introduction

A Medicare Supplement Insurance policy, also known as a Medigap policy, is health insurance sold by private insurance companies to fill the “gaps” in Original Medicare coverage. These gaps in coverage include deductibles, co-insurance, and co-payments. When you purchase a Medigap policy, you will pay a monthly premium in addition to your Medicare Part B premium. Medigap policies must follow federal and state laws. These laws are for your protection. The front of a Medigap policy must clearly identify it as “Medicare Supplement Insurance.”

Group Policies

Group Medigap policies can be offered by an employer as a part of a retirement package, or obtained through an organization that offers this type of insurance to its members (i.e. The American Legion). The employer or organization will determine how and when the policy will pay. Benefits covered by these group policies will vary based on how the policy is structured.

Not all retirement plans are Medigap policies. Many insurance policies offered by employers, labor organizations, or trustees of a fund established by an employer or labor organization are not Medicare Supplement Policies.

Individual Policies

Individual Medigap policies are available for purchase from private insurance companies. Originally, these policies covered a variety of benefits. Medigap policies changed with the Omnibus Budget Reconciliation Act (OBRA) of 1990. As of January 1, 1992, insurance companies can only sell you a “standardized” Medigap policy. These policies must all have specific benefits so that you can easily compare.

Medigap Policy Requirements

As a Medicare beneficiary, you have protections based on federal and state laws. Insurance companies must meet certain requirements in offering Medigap policies. These requirements include:

- **Outline of Coverage:** Insurance agents must give each applicant an outline of coverage summarizing the policy's benefits and features.
- **30-Day Free Look:** Once you receive the certificate or policy, you have 30 days to review the policy and return it for a full refund of premiums paid. This is called a "free look period." If the certificate or policy is mailed to you, the 30 day free look begins the date of the postmark on the envelope.
- **Pre-existing Condition:** While the insurance company can't make you wait for all your coverage to start, it may be able to make you wait for coverage for a pre-existing condition. A pre-existing condition is a health problem for which you have received treatment before the date a new insurance policy begins.
    - If you have a health problem before your Medigap policy starts, the insurance company can refuse to cover that health problem for up to six months. This is called a pre-existing condition waiting period.
    - The insurance company can only use this waiting period if your health problem was diagnosed or treated during the six months before the Medigap policy starts.
    - If you buy a Medigap policy during you Medigap Open Enrollment and you had at least six months of health coverage that qualifies as "creditable coverage", the company cannot apply a pre-existing waiting period.
    - If you had less than six months of creditable coverage, this waiting period will be reduced by the number of months you had creditable coverage. For example, if you had four months of creditable coverage, the waiting period would be reduced to two months.
    - Creditable coverage for Medigap policies is defined as any other health coverage you had prior to applying for a Medigap policy, without a break in coverage longer than 63 days.

These types of health coverage may be considered creditable coverage:

- A group health plan (i.e. employer or union plan)
- A health insurance policy
- Medicare Part A or Part B
- Medicaid
- A medical program of the Indian Health Service or tribal organization
- TRICARE (military retirees and dependents)
- A Federal Employees Health Benefit plan
- A public health plan
- COBRA
- SCHIP (State Children's Health Insurance Program)

The following are not considered creditable coverage:

- Hospital indemnity insurance
- Specified disease insurance (i.e. cancer insurance
- Vision or dental plans
- Long-term care policies

If you buy a Medigap policy when you have special Medigap protections (also called guaranteed issue rights), the insurance company cannot use a pre-existing condition waiting period.

If you are replacing a Medigap policy, the new company will waive any waiting periods that apply if you were covered under the old policy.

- **Guaranteed Renewable:** If you purchased your Medigap policy after 1990, the Medigap policy is required to be guaranteed renewable. This means the insurance company can only drop you if you stop paying your premium, you aren't truthful about something under the policy, or the company goes bankrupt.

- **Coordination of Benefits:** Medigap policies may not contain benefits that duplicate benefits provided by Medicare. This means the policies will not duplicate any payments Medicare has made. It also means policies will not

usually cover services that Medicare would not approve. Exception: some policies will pay for additional benefits not covered by Medicare (such as foreign travel, preventive care, and Part B excess charges).

- **Canceling a Group Master Policy:** When a group policyholder cancels their Medigap group master policy, the insurance company must offer each insured beneficiary the opportunity to convert their group coverage to an individual Medigap policy.

- **Duplication of Coverage:** It is illegal for an agent to knowingly sell you a second Medigap policy if you already have a Medigap policy or are in a Medicare Advantage Plan. When you buy a Medigap policy to replace a current policy, you must state in writing that you intend to cancel the first policy after the new policy becomes effective.

- You should never cancel a Medigap policy until the new one is in your hands and you have decided to keep it. Just because you want to switch plans does not mean the insurance company has to sell you the plan. If you are not in your Medigap Open Enrollment Period or have a Guaranteed Issue, it is up to the company to choose whether to sell you a plan.

- **Medicaid and Medigap:** There are some special situations when it comes to Medicaid and Medigap policies.

    - If you have a Medigap policy and then become a Medicaid member, you can suspend your Medigap policy within 90 days of receiving Medicaid coverage. This suspension can be for up to two years. During this time, you will not be required to pay your premiums, but your policy will not pay for benefits. At the end of the suspension, you can restart your policy without new medical underwriting or pre-existing condition waiting periods. As of January 1, 2006, if you suspend your policy and it included drug coverage, you can still get your policy back but without the drug coverage benefit.

    - If you already have Medicaid, an insurance company can sell you a Medigap policy only if:

        - Medicaid pays your Medigap policy premium, or

- Medicaid pays your Part B premium as part of the Medicare Savings Program

Medigap Coverage

Pre-Standardized Policies

If you have a Medigap policy purchased before 1992, then it is most likely a pre-standardized policy. In Indiana, the standardization law does not affect the pre-standardized policies. Medicare beneficiaries were not required to purchase a standardized policy. While these policies can no longer be sold, as long as the policies are in effect, the benefits will still be covered. These policies must be reviewed in order to determine what benefits are covered by the policy.

Basic benefits for pre-standardized policies included co-payment coverage for Parts A and B, the first three pints of blood, and coverage for an additional 365 days of hospitalization (paid at 90%). Insurance companies added various other benefits to these policies and combined them in a number of ways. Many of these policies offered excellent prescription drug coverage.

Medigap Standardization

Medigap policies changed with the Omnibus Budget Reconciliation Act (OBRA) of 1990. As of January 1, 1992, insurance companies can sell you a "standardized" Medigap policy.

There are currently ten standardized plans that can be sold in any state. These plans were developed by the National Association of Commissioners (NAIC). They are labeled Plans A through N.

- Each standardized plan will be identical in benefits from company to company; however, premiums for each plan may vary from company to company.
- A state may limit the number of plans sold in that state to less than ten, but plan A and Plan C or F must be included as one of the plans for sale.
- In Indiana, all Medigap insurance companies must offer Plan A but can choose the sell any of the other nine plans. Other than Plan A, the insurance companies in Indiana are not required to sell any other plan.
- Not all standardized plans are offered in every state.

- Some states are exempted from federal standardization due to programs in place prior to the law being enacted (Minnesota, Massachusetts, and Wisconsin).
- Some states allow additional benefits to be offered by the insurance company,
- The only U.S. areas where standardization is not in effect are Guam, American Samoa, and the Northern Mariana Islands.

The Medicare Improvements for Patients and providers Act (MIPPA) of 2008 changed many things about Medigap plans. Basic benefits have changed, there are new plans, and some plans are no longer available for purchase. These changes went into effect for plans with an effective date of June 2010. Plans issued with an effective date 1991 through May 2010 are now called 1990 Plans, and plans with an effective date June 2010 and after are referred to as 2010 Plans.

1990 Plans

Standardized Medigap plans issued 1991 through May 2010 are called 1990 plans. These plans are no longer available for purchase; however, as Medigap policies are Guaranteed Renewable, these plans are still in effect and the benefits covered are not changed by the MIPPA Act. Each standardized Medigap policy must cover basic benefits. Plans A through J have one set of standardized benefits and plans K and L have another set. Most policies pay some, if not all, of the Medicare coinsurance and co-payments

In addition, Medigap policies can offer “Extra Benefits”. These benefits can cover such things as Part A and/or Part B deductibles, skilled nursing co-payments, foreign travel, preventive care, and the Part B excess charge.

Basic Benefits for 1990 Plans

Medicare Part A Co-Payment and Hospital Benefits

The amount you must pay for days 61-150 in a hospital benefit period. This benefit also covers an additional 365 more days after your Medicare benefits are used up.

Part A Deductible

The amount you are responsible for before Medicare will begin to pay for an inpatient hospital stay in each benefit period. Plans B through J will pay 100% of the deductible; Plan K pays at 50% and Plan L pays at 75%.

Part B Deductible

The initial amount that you must pay each year before Medicare will begin to pay Part B services. Plans C, F and J will pay 100% of the deductible.

Part B Excess Charge

The difference between Medicare's approved payment amount and the doctor's or health care provider's actual charge, subject to any limiting charge. Plans F, I and J pay 100% of the excess charge; Plan G pays 80% of the excess charge.

At-Home Recovery

If you have Plans D, G, I or J and you receive Medicare-covered home health benefits, the Medigap policy may pay up to $40 per visit for additional, non-Medicare covered visits to assist you with Activities of Daily Living (ADLs) during recovery from an illness, injury, or surgery. Certain limits apply such as:

- Total number of at-home recovery visits cannot exceed the total number of Medicare covered visits.
- After the date of the last home visit covered by Medicare, the policy will only pay for benefits for up to eight additional weeks.
- The policy pays maximum of $1,600 per year.
- The visits are limited to four hours in duration, $40 per visit and, seven visits per week.

Preventive Care

If you have Plan E or J, you may pay nothing for routine yearly checkups and any non-Medicare covered preventive services your doctor recommends. This benefit has a $120 per year limit.

Note: Plans H through J purchased prior to January 1, 2006, included prescription drug benefits. Plans H and I offered a Basic Drug Benefit – You pay an annual $250 deductible and the Medigap plan pays 50% of your prescription drug costs up to a maximum of $1,250 per year. Plan J offered Extended Drug Benefit – You pay an annual $250 deductible and the plan pays 50% of your drug costs up to $3,000 per year.

After January 1, 2006, Medigap policies could no longer be sold with the drug benefits as they did not provide coverage as good as the Medicare Prescription Drug Plans (PDP). Beneficiaries who had plans that offered drug coverage could choose to do one of the following:

- Keep their Medigap policy and its drug coverage,
- Purchase a Medicare PDP and drop their Medigap policy's drug benefit, or
- If they purchased a Medicare PDP before May 15, 2006, they had a guaranteed issue to switch to another Medigap policy.

You can drop the Medigap policy's drug coverage only if you purchase a Medicare PDP. If you have drug coverage that is considered creditable coverage for a PDP (such as a VA, retirement benefits, etc.), you cannot drop your Medigap policy's drug benefit. Creditable coverage is not the same as a Medicare PDP